Reyvow (lasmiditan)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Criteria for Approval: *(All of the following criteria must be met)*

- ❑ 18 years of age or older.
- ❑ Diagnosis of Migraine Headaches as per established criteria from International Headache Guidelines. (see website https://www.ihs-headache.org/ichd-guidelines for guidelines)
- ❑ Trial and failure of two triptans or contraindication:

  Triptan: _____ Dates of Use: _____ Details of Failure: _____

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- ❑ Trial and failure of a CGRP:

  CGRP: _____ Dates of Use: _____ Details of Failure: _____

Quantity Limit: Maximum of 8 tablets per 30 days.

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date